

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL286865783M Date Concluded: April 20, 2023

Compliance #: HL286869928C

Name, Address, and County of Licensee

Investigated:
Hyatt House
231 Washington Street
Holdingford, MN 56340
Stearns County

Facility Type: Assisted Living Facility (ALF) Evaluator's Name:

Jana Wegener, RN, Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):

The facility abused a resident when they restrained the resident in his room using a baby gate.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was substantiated. The facility was responsible for the maltreatment. One month after the resident was admitted to the facility the resident was found alone outside. The facility determined the resident required one on one staff supervision to ensure the residents safety. The facility was unable to provide one to one staffing for the resident and instead restrained the resident in his room using a baby gate. The facility lacked documentation of physician orders for the restraint, documentation of alternative interventions attempted, and specific unsafe behaviors related to the use of the restraint. The restraint was in place for over eight months.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's county case manager and medical provider. The investigation included review of resident's medical record, medication and treatment administration records, incident reports, after visit summaries, signed provider orders, and facility policies and procedures. In addition, the investigator observed the baby gate restraint in use, and staff provision of cares.

The resident resided in an assisted living facility with diagnoses including developmental delay, non-verbal, blindness, and Diabetes Meletus type II.

The resident's most recent assessment, indicated the resident was developmentally delayed, had a language barrier and was not able to communicate, was legally blind, had poor safety awareness, and was unable to walk without staff assistance and scooted on his bottom on the floor to mobilize. The assessment identified the resident was at risk for elopement, wandered and required frequent redirection.

A facility incident report indicated one month after admission to the facility the resident eloped and was found outside alone. The incident report indicated staff were to provide one to one supervision to the resident to prevent recurrence.

The following day the resident's service plan was updated and indicated if staff were unable to provide one to one supervision, the resident should be in his room with a baby gate up to ensure his safety. The service plan identified the resident wandered with elopement tendencies and indicated staff would provide redirection and supervision when he was out of his room.

Three months later, the resident's signed Physician's Orders indicated the facility requested a physician order for use of a baby gate on the resident's door when staff were unable to be with the resident. The physician wrote, "No to use of safety gate." Although the physician did not provide an order to use the baby gate as a restraint for the resident, the facility continued to restrain the resident using the baby gate.

While onsite the investigator observed the resident in his room lying in bed and a baby gate was across the doorway. The resident made periodic, repetitive vocalizations including moaning and high-pitched sounds until staff responded to the resident.

The residents record indicated staff documented when the baby gate restraint was used. The documentation indicated most days the resident was in his room with the baby gate in place for up to seven hours at a time. The documentation indicated the baby gate restraint was put into place after the evening meal and remained in place all night until the resident went out for breakfast the following day.

When interviewed facility staff stated the resident liked to be around other residents and staff. The staff stated other residents had yelled, swore, kicked at the resident, and threatened to

harm the resident due to the residents' loud vocalizations. If staff were not able to be with the resident, he was in his room with the gate up. Staff stated the resident was unable to remove the baby gate and could not get out of his room with the gate in place. Staff stated the resident had declined recently and was more resistive with cares, refused to walk with staff and scooted on the floor instead, had increased vocalizations, decreased intake, and increased rocking motions. Staff stated the resident did the rocking when he was upset or sad.

One staff member stated the resident does not go towards the baby gate anymore to attempt to get out of his room. The staff stated when the residents' vocalizations got loud, they knew the resident was done "being cooped up" and staff would let him out of his room to "roam a bit".

The facility nursing staff stated the resident was developmentally delayed and had the cognition of a one or a two-year-old. The nurse stated the baby gate was needed if staff were busy and not able to monitor him. The nurse stated she was aware the baby gate was a restraint, and the resident was unable to exit his room with the baby gate in place. The nurse stated they were unable to get a physician order for the restraint, and she was unsure what other interventions were attempted to ensure the residents safety instead of restraining the resident.

When interviewed facility leadership stated they were aware using a baby gate to confine the resident to his room was considered a restraint. Leadership staff stated they tried to get a provider order for the baby gate, however, the provider refused because it restricted the resident's rights. Leadership staff stated they continue to use the baby gate because "safety was more important". Leadership staff stated because of the resident's history of elopement, the resident was restrained in his room with the baby gate if staff were unable to be one on one with the resident. Leadership staff stated the facility had a door sensor that would alarm if the resident opened the door going outside the facility, but it was only turned on when the baby gate was down, and the resident was out of his room. The alarm sounded when anyone came in and out of the door, so it was generally turned off during the day. Leadership indicated they had not implemented any other interventions to ensure the residents safety besides restraining the resident in his room using the baby gate.

The resident's family member stated after the resident was found outside the facility alone, the facility put a baby gate up to keep the resident in his room until they figured out what else they could do to keep the resident safe. The family member stated the resident has been restrained in his room for approximate eight months and was not aware if the facility had tried to do anything else to ensure the resident was safe. The family member stated on several occasions when visiting the facility, staff were observed sitting at the desk and the resident was restrained in his room with the baby gate in place. The family member stated the resident had lost weight and appeared more thin than usual.

The resident record lacked clear and consistent documentation of the residents functional, behavioral, or health status. The facility had no documentation of the resident's weights, and

lacked documentation regarding meal intake, specific unsafe behaviors, and interventions attempted prior to using the restraint.

In conclusion, abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.

"Abuse" means:

- (a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
- (1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
- (2) the use of drugs to injure or facilitate crime as defined in section 609.235;
- (3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
- (4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

- (b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
- (1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
- (2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening
- (3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and (4) use of any aversive or deprivation procedures for persons with developmental disabilities or
- related conditions not authorized under section 245.825

Vulnerable Adult interviewed: No - unable Family/Responsible Party interviewed: Yes Alleged Perpetrator interviewed: N/A

Action taken by facility:

No action taken.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4890 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

CC:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Sterns County Attorney
Holdingford City Attorney
Holdingford Police Department

Minnesota Department of Health

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Minnesota Department of Health

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rights; (2) provide services i with the Nurse Practi 148.285; (3) utilize a person-condelivery process; (4) have and maintain health care activities registered nurse, including the Nurse Practice 148.285; This MN Requirement by: Based on observation review, the licensee of person-centered plandignified service deliversident (R1). R1 had was psychosocially hutilized a baby gate recommalised and including serious or a violation that harmed not including serious or a violation that has serious injury, impair issued at a isolated serious injury, impair issued at a isolated serious injury, impair issued at a isolated serious injury occasion. The findings include: R1 was admitted to the with diagnoses include:	entered planning and service n a system for delegation of to unlicensed personnel by a luding supervision and egated activities as required e Act in sections 148.171 to nt is not met as evidenced n, interview and record failed to ensure nning and appropriate very process for one of one d a decline in function and larmed when the facility estraint to confine R1 to his d in a level three violation (a l a client's health or safety, injury, impairment, or death, is the potential to lead to ment, or death), and was ecope (when one or a limited expressionally).	0.430			

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0 450	LALD-C responded one-year-old and relation to the with R1 one to oused to keep him satisfies to make a communication from R1 was out of his restaff had time to make the evening. On March 14, 2023 communication from the evening. On March 14, 2023 communication from the evening. On March 14, 2023 communication from the evening to communication from the evening to make the communication from the comm	n LALD-C to CCM-F indicated that R1 was essentially a equired constant supervision. The facility did not have staff to the facility was affe. The facility did not have staff to the facility was not locked and fact the door. The facility was not locked and fact the door. The facility was not locked and fact the door. The facility was not locked and fact the door. The facility was in his room and expressed the family had sing R1 a lot of sadness. The facility had sing R1 a lot of sadness. The facility had sing R1 a lot of sadness. The facilities having a fact the facility had sation of the facilities having a fact the facility had sation of the facilities having a fact the facility had sation of the facilities having a fact the facility had sation of the facilities having a fact the facility had sation of the facilities having a fact the facility had sation of the facilities having a fact the facility had sation of the facilities having a fact the facility had sation of the facilities having a fact the facility had sation of the facilities having a fact the facility had sation of the facility to fact the facility to sate.	0 450			

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0 450	R1 was out of his rosee everyone as the On March 27, at 1:7 communication from CCM-F expressed concern was R1 lead oversight, as he may CCM-F provided an system the facility obaby gate. LALD-C On April 7, 2023, Calander LALD-C with no reservation in use included 14, 2022, to April 10 included date, time or no section for if the document indicated was in his room with times for up to sever day unless the residual documentation indicated was in his room with times for up to sever day unless the residual documentation indicated documentation indicated document	m LALD-C to CCM-F indicated from regularly, and R1 could bey walk by. 10 p.m. an email of CCM-F to LALD-C indicated she understood the primary aving his room without staff by try to leave the facility. In amazon link for a door alarm could implement to remove the failed to respond. CM-F sent a follow up email to sponse as of April 10, 2023. It documentation from January 10, 2023. The document resident location, and a yes he gate was in use. The I most of the day the resident he the baby gate in place, at the hours at a time during the dent was out for meals. The cated the baby gate was put evening meal and remained in 1911 until the resident went out				

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0 450	at 10:20 a.m., a ball doorway of R1's roof from leaving his roof heard moaning in high-pitched vocalized observed walking be however, did not enface. On April 6, 2023, at personal (ULP)-D staff and other resident was in his because when R1 sticked him. ULP-D baby gate anymore loud they knew he wand "staff let him out of April 6, 2023, at facility used a baby other resident's yell when he was crawlloud noises. ULP-A the baby gate to ge indicated the baby gout for meals or if the ULP-A indicate the night because R1 of out of his room. On April 6, 2023, at interview, ULP-D staff and cout of his room.					

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0 450	were "way worse", a hollering, increased vocalizations, was refused to walk, refused to walk, refused to walking with staff. Ukicked and swore at the floor. On April 6, 2023, at (RN)-B stated R1 wong assistance, and socihands and feet. RN cognition of a one-used the baby gate safety. RN-B stated meals a few hours a unable to remove the restraint. RN-B state physician order for there a plan for staff of the restraint. RN-of other intervention to keep R1 safe. On April 6, 2023, at used the baby gate R1, and it was in play seven hour evening past couple months stubborn and resist toileting, refused to scoot everywhere of R1 has had a decreated and more rocking by the seven hour evening past couple months at the seven hour evening pa	ree months R1's behaviors and described R1 had more				
	On April 10, 2023, a	at 4:32 p.m. LALD-C stated R1				

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0 450	supervision becaus such as reached to put things in his mon facility exit. LALD-C supervision, but the so the baby gate was afe. LALD-C states on the facility exit do entered or exited the unless R1 was out as the was aware the tried to get a doctor refused, and told the rights. LALD-C states important, and the facility gate without a stated since R1 elonot implemented and R1 safe other than stated she was unakeep R1 safe to rembeing provided informational arm system from A facility policy and Plan" dated Decemindividualized service all residents based. No further information	e he was always into things touch a fan, touched outlets, uth, and went toward the stated R1 needed one to one y did not have enough staff, as implemented to keep R1 d there was an alarm system for that chimed when anyone e facility, but it was turned off of his room. LALD-C stated baby gate was a restraint and 's order, but R1's provider em it would restrict R1's ed R1's safety was more facility continued to use the physician order. LALD-C foed from the facility they had by other interventions to keep use the baby gate. LALD-C ware of any other options to nove the baby gate, despite mation for an alternative CCM-F. procedure titled "Service ber 1, 2016, indicated an see plan was implemented for on assessed needs.	0 450			
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	(11) develop and im determining its staff	plement a staffing plan for ing level that:				

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MATTHOUSE LLC MAMMARY STATEMENT OF DEFICIENCIES DEPOSITION PROVIDERS PLAN OF CORRECTION CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYINS INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETE DEATH OF CORRECTIVE ACTION SHOULD BE COMPLETE DEFICIENCY) O 470 Continued From page 8 O 470 Continued From page 9 Continued Fr	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
Inclining Foreign (24) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) O 470 Continued From page 8 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures sufficing staff or resident in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of providing or summoning the appropriate assistance; and (v) capable of providing or summoning the appropriate assistance; and (v) capable of nessed falled to develop and implement a staffing plan to meet the needs of all residents when one of one resident (R1) was restrained in his room for prolonged periods of	HVATT HOUSE LLC	231 WASI	HINGTON ST	REET		
PRÉÉIX TAG REGULATORY OR LSC IDENTIFYINS INFORMATION) 0 470 Continued From page 8 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to meet the needs of all residents when one of one resident (R1) was restrained in his room for prolonged periods of	HIAII HOUSE LLC	HOLDING	FORD, MN	56340		
(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to meet the needs of all residents when one of one resident (R1) was restrained in his room for prolonged periods of	PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to meet the needs of all residents when one of one resident (R1) was restrained in his room for prolonged periods of	0 470 Continued From pa	age 8	0 470			
time due to lack of staffing. This had the potential to affect all residents who resided in the facility and staff. This practice resulted in a level two violation (a	(i) includes an evaleast twice a year, staffing levels in the (ii) ensures sufficienthe scheduled and unscheduled need by the residents' as on a 24-hour per desident (iii) ensures that the and effectively to it and to emergency, situations affecting (12) ensure that or available 24 hours who are responsible requests of residents afety needs. Such (i) awake; (ii) located in the subuilding, or on a confacility in order to reamount of time; (iii) capable of come (iv) capable of prography appropriate assistate (v) capable of follows: This MN Requirem by: Based on observative review, the license implement a staffing residents when on restrained in his rottime due to lack of to affect all resider and staff.	duation, to be conducted at of the appropriateness of e facility; ent staffing at all times to meet reasonably foreseeable s of each resident as required assessments and service plans ay basis; and e facility can respond promptly individual resident emergencies life safety, and disaster staff or residents in the facility; ne or more persons are per day, seven days per week, le for responding to the ints for assistance with health or in persons must be: ame building, in an attached entiguous campus with the espond within a reasonable inmunicating with residents; widing or summoning the ence; and wing directions; interview, and record to failed to develop and in the facility of the or prolonged periods of staffing. This had the potential its who resided in the facility				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
	20606	B. WING		04/0	
	28686	B. Wii (6		04/0	6/2023
NAME OF PROVIDER OR SUPPLIER HYATT HOUSE LLC	231 WAS	DDRESS, CITY, S HINGTON ST SFORD, MN 5			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
resident's health or cause serious injury was issued at a wide problems are pervasually failure that has affer a large portion or a large portion on-verbal, blindness included and the large portion of the large portion	potential to have harmed a safety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic ected or has potential to affect all of the residents).	0 470			
ensure his safety, i the day after R1 el	nitiated on August 18, 2022, oped from the facility. 2022, R1's signed "Physician's				
order for use of a boor for safety whe	cated the facility requested an aby gate on the resident's en staff were unable to be with ders indicated, "No to use of				
	tion for the baby gate use from to April 10, 2023, included				

Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	SURVEY LETED
		28686	B. WING		04/0	; 6/2023
NIAME OF			<u> </u>		1 04/0	0/2020
NAME OF	PROVIDER OR SUPPLIER		HINGTON ST	STATE, ZIP CODE		
HYATT H	OUSE LLC		FORD, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PRÉFIX TAG	`	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
0 470	Continued From pa	ge 10	0 470			
	section for if the gat indicated in general with the baby gate i to seven hours at a out for meals. The of baby gate was put i meal and remained the resident went or day.	location, and a yes or note was in use. The document the resident was in his room n place during the day for up time, unless the resident was documentation indicated the nto place after the evening in place during the night until ut for breakfast the following				
	personnel (ULP)-D on per shift and cou	stated they only have two staffuld not keep an eye on R1 all ed the baby gate to keep R1				
	(RN)-B stated staffing used a baby gate to safety when staff we	1:48 p.m. registered nurse ng was an issue, and staff confine R1 to his room for his ere unable to be with R1. by gate was down for meals a				
	used the baby gate	2:45 p.m. ULP-E stated staff when they could not be with during a seven-hour evening				
	licensed assisted liver R1 required constant LALD-C stated they	at 4:32 p.m. the facility ving director (LALD)-C stated nt one to one staff supervision. It did not have enough staff to ey used a baby gate to keep				
	The facility staffing provided.	plan was requested and not				
	The facility policy ar	nd procedure titled "Staffing,				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE	SURVEY LETED
				c	;
	28686	B. WING		04/0	6/2023
NAME OF PROVIDER OR SUPPLIER HYATT HOUSE LLC	231 WASH	DRESS, CITY, S HINGTON ST FORD, MN			
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
dated August 1, 202 persons would be a seven days per wer residents' health ar plan would provide needs of the reside resident's needs we plan, and acuity of resident's most recindicated the staffir revised a minimum No further informat	Plan, and Daily Schedule" 21, indicated one or more available 24 hours per day ek who are to respond to ad safety needs. The staffing sufficient staff to meet the attis 24 hours a day. Each ere identified in the service the resident was based on the ent assessment. The policy ag plan would be reviewed and of two times per year.	0 470			
that services are fir facility shall finalize (b) The service platinclude a signature facility and by the reagreement on the service plan must be resident reassess of facility must provide about changes to the and how to contact Long-Term Care are for Mental Health at (c) The facility must services required by (d) The service plate	,	01640			

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		28686	B. WING		04/0) 6/2023
NAME OF PROVID		231 WASH	DRESS, CITY, S			
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
inclument (e) So the control of the	applicable. taff providing surrent written surrent written surrent written surrent written surrent written surrent written surrent was implement documented at ent (R1). practice resultation that did not be serious injurging including sued at an isued number of reliation has occurrent findings included as admitted to diagnoses included as admitted as admitted as admitted as adm	a change in a resident's fees dervices must be informed of service plan. The service plan are service plan are service plan are service feel and services provided accurately for one of one are service are allowed and services provided accurately for one of one are service when a resident's health or potential to have harmed a safety, but was not likely to be a service (when one or a service) (when one or a ser	01640			
		ers for R1 to have monthly				

Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		28686	B. WING		04/0) 6/2023	
	NAME OF PROVIDER OR SUPPLIER STREET A 231 WAS HYATT HOUSE LLC HOLDIN				-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
01640	initiated on admission R1's service plan day indicated R1 would checks every 15 min his needs and ensure staff would walk R1 independence with indicated staff would and complete monto. On April 6, 2023, at observed in the document was in bed. During 10:40 a.m. R1 was with intermittent lou 11:07 a.m. Unknow by R1's room period engage R1 face to personnel (ULP)-D a.m. On April 6, 2023, at the past few months resistive with cares, high-pitched yelling able to walk with stanow R1 refused to whis bottom on the flow on April 6, 2023, at (RN)-B stated R1 whom-verbal, required and scooted on his feet to mobilize. RN aware of changes in On April 6, 2023, at Changes in Con April 6, 2023, at Co	on the 18th of every month, on. ated March 30, 2023, have face to face safety nutes each shift to address re safety. The plan indicated to all meals for optimal ambulation. The plan document R1's meal intake hly weight monitoring. 10:20 a.m. a baby gate was arway of R1's room, while R1 continuous observation from heard moaning in his room d high-pitched vocalizations at an staff were observed walking dically, however, did not face until unlicensed entered R1's room at 11:23 11:30 a.m. ULP-D stated in a R1 had declined, was more and had more episodes of the ULP-D stated R1 used to be aff assistance everywhere, but walk and wanted to scoot on					

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		28686	B. WING	_	04/	C 06/2023	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	•			
HYATT H	IOUSE LLC		HINGTON STE SFORD, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
01640	Continued From pa	ge 14	01640				
		, refused to stand, refused to n his bottom instead, and had					
	• •	8 a.m. R1's family member weight and was now "skin and					
	2023, to April 9, 202 services provided e 15-minute checks had one, and eight shirt checks. The record had not completed record failed to indicate only had documents	ery Record from March 1, 23, included documentation of each shift. The record indicated had not consistently been fts had not completed the failed to indicate which shift the checks. The service cate R1 walked to meals, and ation for ambulation three cord indicated staff ambulated rch and April 2023.					
	monitoring ever bei admission, and R1' consistent, clear, a	any documentation of weight ng completed since s intake documentation lacked curate documentation to decreased intake or weight					
	had been more stul walk. LALD-C state weights being done they did not have a	at 4:32 p.m. LALD-C stated R1 bborn lately and refused to d they had no record of R1's since admission, because scale R1 could use. LALD-C hts were done at the clinic but ecord of them.					
	R1's behavior mana were requested, no	agement plan, and reviews ne were provided.					
		procedure titled "Service ber 1, 2016, indicated an					

Minnesota Department of Health

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					C	,
		28686	B. WING		04/0	6/2023
	NAME OF PROVIDER OR SUPPLIER HYATT HOUSE LLC STREET A 231 WA HOLDIN					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
01640 C	ontinued From pag	ge 15	01640			
		ce plan was implemented for on resident assessed needs.				
20 in	021, indicated staf	dent Records" dated August 1, if would document health vices provided in the resident				
N	o further informati	on was provided.				
	IME PERIOD FOR 4) days.	R CORRECTION: Fourteen				
	44G.91 Subd. 4 (a ervices) Appropriate care and	02310			
liv re se	ing services that a sident's needs an	the right to care and assisted are appropriate based on the d according to an up-to-date to accepted health care				
by Bare ca ar in th hi de	ased on observations of the licensee of the licensee of the license of the license of the licensee of the lice	ent is not met as evidenced on, interview, and record failed to provide appropriate ensure dignified and enterventions were e of one resident's (R1) when baby gate to restraint R1 in periods of time. R1 had a and was psychosocially				
vi no or	olation that harme ot including serious a violation that ha	ed in a level three violation (and a client's health or safety, s injury, impairment, or death, as the potential to lead to irment, or death), and was				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		28686	B. WING	B. WING) 6/ 2023
	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE		
HYAIIH	OUSE LLC	HOLDING	SFORD, MN	56340		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
02310	Continued From pa	ge 16	02310			
	limited number of cl	d scope (when one or a lients are affected or one or a laft are involved or the led only occasionally).				
	The findings include	2 :				
	11 days prior to faci was a social person he could be around indicated R1 should to improve strength	oport plan dated July 7, 2022, lity admission, indicated R1 who was most happy when others. The assessment I be encouraged to walk daily and endurance. The ed a goal was to have R1 live the increased social				
	with diagnoses inclu	the facility on July 18, 2022, uding developmental delay, ss, and Diabetes Mellitus.				
	2023, indicated R1 legally blind, memo awareness, languaged delay, and had exit assessment indicated	assessment dated March 30, was visually impaired and ry impaired, had poor safety ge barriers, developmental seeking behavior. The ed R1 had a behavior hat would be evaluated by the				
	R1's behavior mana were requested, no	agement plan, and reviews ne were provided.				
	month after admiss resident eloped from outside alone. The	ated August 17, 2022, one ion to the facility, indicated the n the facility and was found incident report indicated staff to one supervision to prevent				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		28686	B. WING		04/0) 6/2023
	PROVIDER OR SUPPLIER	231 WASH	DRESS, CITY, S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02310	Orders Sheet" indicorder for use of a bedoor to prevent the staff were unable to orders indicated the to use of safety gate included weight most the facility each most on admission. R1's service plan desidentified R1 wands tendencies and indirection and suphis room. The plan to provide one to orhis room with a bab. The baby gate was August 18, 2022, the facility. The plan face to face safety address his needs indicated staff would would provide assist independence with	ge 17 2022, R1's signed "Physician's rated the facility requested an aby gate on the resident's resident from exiting when be with R1. The signed physician documented, "No e". In addition, the orders nitoring to be completed by nth, which had been initiated ated March 30, 2023, ared with elopement cated staff would provide ervision when he was out of indicated if staff were unable he supervision R1 should be in by gate up to ensure his safety. documented as initiated on the day after R1 eloped from an indicated R1 would have checks every 15 minutes to and ensure safety. The plan did walk R1 to all meals and stance and support for optimal ambulation. The service plan e and monthly weight				
	2023, to April 9, 202 services provided e 15-minute checks had one, and eight shirt checks. The record had not completed record failed to indicate only had documents	ry Record from March 1, 23, included documentation of ach shift. The record indicated ad not consistently been its had not completed the failed to indicate which shift the checks. The service cate R1 walked to meals, and ation for ambulation three cord indicated staff ambulated rch and April 2023.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	` '	(X3) DATE SURVEY COMPLETED		
		28686	B. WING		04/	C 06/2023
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
HYATT H	IOUSE LLC		SFORD, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
02310	Continued From pa	ge 18	02310			
	monitoring ever bei admission. R1's do consistent, clear, ad	any documentation of weight ng completed since ocumentation of intake lacked ocurate documentation to decreased intake or weight				
	On November 30, 2022, at 2:25 p.m. R1's progress note indicated R1 had been out of his room all day, went in and out of the dining room, and looked out the front door. The note indicated R1 was doing very well and expressed no safety concern.					
	progress note indicated R1 goes to look out the door.	D22, at 1:17 p.m. R1's ated R1 had been out of his one very well again. The note to the front door and sits to The note indicated R1 enjoyed g room to watch staff work in				
		022, at 1:20 p.m. R1's ated R1 had been out of his o safety concerns.				
	progress note indic	2022, at 10:15 p.m. R1's ated R1 had done great being day, went up and down the ne dining room.				
	progress note indice the facility and had R1 went to the facility went into the dining R1's progress notes April 6, 2023, had notes	2022, at 1:09 p.m. R1's ated R1 was out and about in done well. The note indicated ity doors and looked outside, room, then sat in his chair. Is from December 14, 2022, to documentation of R1 being the baby gate down.				

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Minnesota Department of Health

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		` ,		COMPLETED	
		28686	B. WING		C 04/06/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HYATT H	OUSE LLC		INGTON ST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.)	D BE	(X5) COMPLETE DATE
02310	Continued From pa	ge 19	02310			
	included documents to April 10, 2023. The time, resident location if the gate was in using most days the resident baby gate in place funless the resident documentation indicates into place after the	ion for the baby gate use ation from January 14, 2022, ne document included date, on, and a yes or no section for se. The document indicated ent was in his room with the for up to seven hours at a time was out for meals. The cated the baby gate was put evening meal and remained in the until the resident went out lowing day.				
	for R1 from Novem 2023, included a list touched when not resuch as pulling pap	ion regarding safety concerns ber 16, 2022, to April 10, t of things R1 had grabbed or estrained by the baby gate; ers off a table or eating paper. Sated R1 had gone towards ried to go outside.				
	elopement or elope 17, 2022, and lacked interventions impler effectiveness, or other	documentation of incidents of ment attempts since August ed documentation of mented, redirection provided, ner actions taken to keep R1 use of the baby gate restraint.				
	(CCM)-F to the licer (LALD)-C indicated gate use. In the emunderstood the princhis room without states leave the facility. Confor a door alarm systemplement to remove	n R1's county case manager used assisted living director concerns regarding the baby ail CCM-F indicated she hary concern was R1 leaving aff oversight, as he may try to CM-F provided an amazon link stem the facility could be the baby gate. As of April had failed to respond.				

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMPLETED	
		28686	B. WING		C 04/06/2023	
	PROVIDER OR SUPPLIER	231 WASH	HINGTON ST			
0.40.15	CLIMMA DV CTA		FORD, MN			045)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDERING DEFICIENCY)	D BE	(X5) COMPLETE DATE
02310	Continued From pa	ge 20	02310			
	in bed and a baby gof R1's room. Durin beginning at 10:40 his room with intern vocalizations at 11:0 observed walking be however, did not en unlicensed personn at 11:23 a.m. and a incontinence care. - At 11:45 a.m. ULP seated on the edge down. R1 lowered harms on the edge of bottom using his harms.	10:20 a.m. R1 was observed pate was across the doorway g continuous observation a.m. R1 was heard moaning in nittent loud high-pitched 07 a.m. Unknown staff were y R1's room periodically, gage R1 face to face until lel (ULP)-D entered R1's room ssisted R1 with toileting and P-D left R1's room and R1 was of the bed and the baby gate himself to the floor using his f the bed, then scooted on his ands and feet to propel himself the dining room and pulled for lunch.				
	facility used a baby other residents had at R1 when he was ULP-A stated R1 co and the gate was ta for meals. ULP-A in during the night bed and come out of his remove the baby gate was up be kicked and swore a go near the baby gate vocalizations got love.	10:30 a.m. ULP- A stated the gate to keep R1 safe because yelled, swore at, and kicked crawling around on the floor. Ould not remove the baby gate, aken down when R1 was out dicate the gait was in place cause R1 could open his door is room but he could not ait. 11:30 a.m. ULP-D stated R1 staff and other residents. resident was in his room the ecause other residents had to R1. ULP-D stated R1 doesn't ate anymore, and if his aud, they knew he was "done and "staff let him out of his				

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STATE FORM 1XFG11 1XFG11 1XFG11

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	` ,	(X3) DATE SURVEY COMPLETED C 04/06/2023	
	28686 B. WING		B. WING	B. WING		
	PROVIDER OR SUPPLIER	231 WASH	DRESS, CITY, S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
02310	months R1 had dec cares, and had mor yelling. ULP-D state R1 everywhere, how and scoots on his be On April 6, 2023, at (RN)-B stated R1 we non-verbal, required and scooted on his feet to mobilize. RN cognition of a one- used the baby gate safety. RN-B stated baby gate and it wan did not have enoug supervision R1 nee gate was down for a RN-B stated there we staff to follow the use indicated she was a tried to keep R1 sate indicated she was a tried to keep R1 sate indicated she was a tried to keep R1 sate indicated she was a tried to keep R1 sate have loud vocalizate On April 6, 2023, at had gone towards to redirected. ULP-E sate was in his room with hours during a sever the baby gate was of to be with staff and R1 liked to be aroun residents had used had threatened to he the past few months	dulp-D stated in the past few elined, was more resistive with the episodes of high-pitched ed she used to be able to walk evever, now R1 refused to walk ottom on the floor. 1:48 p.m. registered nurse has developmentally delayed, distaff assistance to ambulate, bottom using his hands and lab indicated R1 had the to two-year-old child, and staff to confine R1 to his room for R1 was unable to remove the sign a restraint, however, they his staff to provide the ded. RN-B stated the baby meals a few hours a day. Was no signed order or plan for se of the restraint. RN-B inaware of other interventions fe besides the baby gait. RN-B into aware of changes in R1's, or incidents involving other disometimes R1 would cry or				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE. ZIP CODE 231 WASHINGTON STREET HOLDINGFORD, MN 55340 (EACH DEPICIENCY MUST BE PRECEDED BY PILL, REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CONTINUED From page 22 refused to walk and scooted on his bottom instead, and had decreased intake. ULP-E indicated R1 had more rocking motions which was what he did when he was sad or upset. On April 10, 2023, at 4:32 p.m. LALD-C stated R1 liked to be around others but required constant supervision. LALD-C stated the exit doors had an alarm that would chime if anyone would come or go from the facility, but indicated it was turred off unless R1 was out of his room. LALD-C stated the yeak on the resident's provider refused to walk the resident's provider refused to sign it because it would "restrict R1's rights". LALD-C stated R1 land had fried to get a physician's order to use the baby gate, but the resident's provider refused to sign it because it would "restrict R1's rights". LALD-C stated R1 land head fried to get a physician's order to use the baby gate, but the resident's provider refused to sign it because it would "restrict R1's rights". LALD-C stated R1 land be a more stubbon lately and refused to walk. LALD-C stated since R1 eloped from the facility hey had not implemented any other interventions to keep R1 safe. LALD-C stated she was unwaver of any other options to keep R1 safe to be able to remove the baby gate. LALD-C stated there were no incident reports of resident's being physically or verbally aggressive toward R1 because the other resident's provider because they did not have a scale R1 could use. LALD-C indicated R1's weights being done since admission. because they did not have a scale R1 could use. LALD-C indicated R1's weights being done as the chinic but	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 231 MASHINGTON STREET HOLDINGFORD, MN 56340 SUMMARY STATEMENT OF DEFICIENCES SUMMARY STATEMENT OF DEFICIENCES SUMMARY STATEMENT OF DEFICIENCES (EACH DEPTOINCY MLST BE PRECEDED BY FULL (ERCHLAROPY OR LSO DENTIFYING INFORMATION) PREFIX TAG COntinued From page 22 refused to walk and scooled on his bottom instead, and had decreased intake. ULP-E indicated R1 had more rocking motions which was what he did when he was sad or upset. On April 10, 2023, at 4:32 p.m. LALD-C stated R1 liked to be around others but required constant supervision. LALD-C stated the exit doors had an alarm that would chime if anyone would come or go from the facility, but indicated it was turned off unless R1 was out of his room. LALD-C stated they did not have enough staff to provide one to one supervision for R1. LALD-C stated she knew the baby gate was a restraint and had irried to get a physician's order to use the baby gate, but the resident's provider refused to sign it because it would "restrict R1's rights". LALD-C stated R1's safety was more important, and they confinitude to use the baby gate. LALD-C stated R1 had been more stubborn lately and refused to walk. LALD-C stated they and not implemented any other interventions to keep R1 safe. LALD-C stated R1 had been more stubborn lately and refused to walk. LALD-C stated they had not implemented any other interventions to keep R1 safe. LALD-C stated they had not implemented any other interventions to keep R1 safe. LALD-C stated they had not implemented any other interventions to keep R1 safe. LALD-C stated to walk. Lated they had no record of R1's weights being done since admission, because they did not have a scale R1 could use. LALD-C			, a Boile Birto.		C	
HYATT HOUSE LLC Ox4 D		28686	B. WING			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 02310 Continued From page 22 refused to walk and scooted on his bottom instead, and had decreased intake. ULP-E indicated R1 had more rocking motions which was what he did when he was sad or upset. On April 10, 2023, at 4:32 p.m. LALD-C stated R1 liked to be around others but required constant supervision. LALD-C stated R1 was always into things like nick knacks, fans, touching outlets, putting things in his mouth, and would go towards the facility exit doors. LALD-C stated the exit doors had an alarm that would chime if anyone would come or go from the facility, but indicated it was turned off unless R1 was out of his room. LALD-C stated they did not have enough staff to provide one to one supervision for R1. LALD-C stated she knew the babby gate was a restraint and had tried to get a physician's order to use the baby gate, but the resident's provider refused to sign it because it would "restrict R1's rights". LALD-C stated R1's safety was more important, and they continued to use the babby gate. LALD-C stated R1 had been more stubborn lately and refused to walk. LALD-C stated R1 had been more stubborn lately and refused to walk. LALD-C stated filty they had not implemented any other interventions to keep R1 safe. LALD-C stated she was unaware of any other options to keep R1 safe to be able to remove the baby gate. LALD-C stated there were no incident reports of resident's being physically or verbally aggressive toward R1 because the other residents didn't make contact with the resident, they only kicked at him. LALD-C stated they had no record of R1's weights being done stince admission, because they did not have a scale R1 could use. LALD-C		231 WASI	HINGTON ST	REET		
refused to walk and scooted on his bottom instead, and had decreased intake. ULP-E indicated R1 had more rocking motions which was what he did when he was sad or upset. On April 10, 2023, at 4:32 p.m. LALD-C stated R1 liked to be around others but required constant supervision. LALD-C stated R1 was always into things like nick knacks, fans, touching outlets, putting things in his mouth, and would go towards the facility exit doors. LALD-C stated the exit doors had an alarm that would chime if anyone would come or go from the facility, but indicated it was turned off unless R1 was out of his room. LALD-C stated they did not have enough staff to provide one to one supervision for R1. LALD-C stated she knew the baby gate was a restraint and had tried to get a physician's order to use the baby gate, but the resident's provider refused to sign it because it would "restrict R1's rights". LALD-C stated R1's safety was more important, and they continued to use the baby gate. LALD-C stated fine R1 had been more stubborn lately and refused to walk. LALD-C stated sine R1 eloped from the facility they had not implemented any other interventions to keep R1 safe. LALD-C stated she was unaware of any other options to keep R1 safe to be able to remove the baby gate. LALD-C stated there were no incident reports of resident's being physically or verbally aggressive toward R1 because the other residents didn't make contact with the resident, they only kicked at him LALD-C stated they had no record of R1's weights being done since admission, because they did not have a scale R1 could use. LALD-C	PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
they had no record of them. A facility policy and procedure titled "Service Plan" dated December 1, 2016, indicated an	refused to walk and instead, and had do indicated R1 had mas what he did who was to be around a supervision. LALD-things like nick knaputting things in his the facility exit door doors had an alarm would come or go the was turned off unled LALD-C stated the provide one to one stated she knew the and had tried to ge baby gate, but the sign it because it we LALD-C stated R1's and they continued stated R1 had been refused to walk. LA from the facility the other interventions stated she was unakeep R1 safe to be LALD-C stated their resident's being photoward R1 because make contact with at him. LALD-C stated their ward R1 because make contact with at him. LALD-C stated their did not have a indicated R1's weights being done they did not have a indicated R1's weights policy and	d scooted on his bottom ecreased intake. ULP-Enore rocking motions which men he was sad or upset. at 4:32 p.m. LALD-C stated R1 others but required constant C stated R1 was always into cks, fans, touching outlets, amouth, and would go towards as. LALD-C stated the exit of that would chime if anyone from the facility, but indicated it as R1 was out of his room. If y did not have enough staff to supervision for R1. LALD-C abby gate was a restraint at a physician's order to use the resident's provider refused to ould "restrict R1's rights". If y is safety was more important, to use the baby gate. LALD-C amore stubborn lately and LD-C stated since R1 eloped y had not implemented any to keep R1 safe. LALD-C aware of any other options to able to remove the baby gate. The were no incident reports of y yically or verbally aggressive the other residents didn't the resident, they only kicked ted they had no record of R1's a since admission, because scale R1 could use. LALD-C this were done at the clinic but of them.				

Minnesota Department of Health

STATE FORM 1XFG11 1XFG11 1XFG11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				C	;
	28686	B. WING		04/0	6/2023
NAME OF PROVIDER OR SUPPLIE		, ,	STATE, ZIP CODE		
HYATT HOUSE LLC		HINGTON ST SFORD, MN			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
02310 Continued From p	age 23	02310			
	vice plan was implemented for do not do not do not de la complexa della complexa de la complexa della complexa de la complexa de la complexa della complexa				
Direct Care Staffindated August 1, 2 persons would be seven days per works and acuity of the resident's needs of the resident's needs would provide needs of the resident's needs works and acuity of resident's most resident's most resident the staffindicated the staffindicated a minimum A policy titled "Resident's indicated staffindicated staffindica	d procedure titled "Staffing, and Plan, and Daily Schedule" 221, indicated one or more available 24 hours per day eek who are to respond to and safety needs. The staffing e sufficient staff to meet the ent's 24 hours a day. Each were identified in the service of the resident was based on the cent assessment. The policy ing plan would be reviewed and an of two times per year. Sident Records" dated August 1, aff would document health ervices provided in the resident				
A policy and proce requested, none v	edure for restraints was vas provided.				
No further informa	ition was provided.				
TIME PERIOD FO (2) days.	R CORRECTION: Two Days				
02360 144G.91 Subd. 8	Freedom from maltreatment	02360			
sexual, and emoti exploitation; and a	e right to be free from physical, onal abuse; neglect; financial Ill forms of maltreatment Vulnerable Adults Act.				
This MN Requirer by:	nent is not met as evidenced				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		` '	X3) DATE SURVEY COMPLETED	
		28686	B. WING		04/0		
		20000			04/0	6/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
HYATT HOUSE LLC HOLDINGFORD, MN 56340							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE	
02360	Continued From page 24		02360				
	Based on interview and document review, the facility failed to ensure one of one of one residents reviewed, (R1) was free from maltreatment. R1 was abused.			No Plan of Correction (PoC) required Please refer to the public maltreat report (report sent separately) for of this tag.	c maltreatment		
	Findings include:						
	The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.						